Rhode Island Department of Health
CONTINUITY OF CARE FORM

Instructions

Fill in all applicable information on pages 1-4. Use N/A in sections that do not apply to patient. Include the patient's full name on all pages.

If the patient is being transferred to another facility the **patient demographic/registration sheet**, copy of **most recent lab results** and the **last 7 days of medication sheets and IV fluid sheets must** be attached and sent with the Continuity of Care Form.

PAGE 1:

Patient Name: Include the patient's full name (Addressograph may be used in right corner if available and clearly legible)
Address: Include the address at which the patient resided prior to this admission regardless of whether they are returning to that address upon discharge.

Address being discharged to: include the address that the patient will be going to upon discharge if different from the patient's home address
Phone: Include the telephone number at the address the patient is being discharged to

Discharging Facility: The name of your facility
Contact Person: The person who should be contacted regarding questions concerning this patient's stay at your facility
Phone/Beeper: The telephone number/beeper number of the contact person listed above

Insurer: The patient's insurance provider
Number: The patient's policy number for the above provider

Inpatient Admission Date: The actual date that the patient was admitted as an inpatient at your facility (DO NOT include dates that the patient may have been on Observation since this is an outpatient status)
Discharge Date: The date the patient is discharged from your facility

Referral to: Insert the name of the facility or the name of the visiting nurse agency that the patient is being referred to for post discharge care
Phone: The telephone number where the above can be contacted

SHADED AREAS TO BE FILLED OUT BY PHYSICIAN:

Principal Diagnosis of this Admission: The diagnosis(es) the patient was being treated for in this facility

Other Active Medical Problems: List all of the patient's other current/active diagnoses

PAGE 1 (continued):

Surgery this Admission: List all surgeries performed on this patient that took place during this admission

Date: List the dates of the above surgeries

Infections this Admission and Site: List all infections that the patient had during this admission and the site of each infection

If the patient has/or has had MRSA, VRE, and/or C-Diff infections fill in the appropriate box:

Active: Check the box if the patient currently has the infection

Resolved Date: Write in the date the patient was noted to have the infection resolved

Prior History: Check the box if the patient has a history of the infection prior to admission to your facility but it has resolved

Does the patient have an Advanced Directive? Includes Durable Power of Attorney for Health Care, Living Will

No: Check this box if the patient does not have any advanced directives

Yes: Check this box if the patient does have an advanced directive

FULL: Check this box if the patient is a full code

DNR: Check this box if the patient has a "Do Not Resuscitate" order while in your facility

CMO: Check this box if the patient has an order for "Comfort Measures Only" while in your facility

Immunization(s) this Admission:

FLU: Check this box if the patient had the Influenza Vaccine while in your facility

Pneumovax: Check this box if the patient had the Pneumonia Vaccine while in your facility

Tuberculin Status, if known:

Neg: Check this box if the patient had a negative result from PPD or chest X-ray in the past 3 months

Positive: Check this box if the patient has ever had a positive PPD or chest X-ray

Unknown: Check this box if you do not know that tuberculin status of this patient

Allergies, list and describe reaction: List all known allergies and describe what happens during an allergic reaction to each

Physician orders/treatments. Please specify number and frequency: List all orders for treatment and care post discharge, including the number of times and frequency of each. Be sure to include the patient's diet, activity orders, and condition at discharge.

All medication(s) to be taken post discharge including those taken prior to admission: List all orders for medication to be given post discharge, be sure to include route, dosage and frequency for each medication.

PAGE 2:

Patient's Name: Include the patient's full name

Instructions Until Next Doctor Visit: Check off the boxes that indicate whether the patient is allowed, needs supervision, or is not allowed to perform each activity listed during the time period from discharge to their next physician visit

Physician's Signature: and **Date**: The signature of the physician completing/verifying the physician orders/treatments, medications, and instructions on pages 1 & 2 of this form and the date completed

Information given to patient on discharge: Check off the boxes that indicate the information given to the patient on discharge and complete the remainder of this section to include when to call the physician, follow–up appointments (if known) and any wound instructions

MEDICATIONS ON DISCHARGE:

1. If the patient is being discharged to home: List the medications the patient will be taking after discharge and the time the next dose is due. **Check the box if prescriptions were given to the patient/guardian for new medications.

2. If the patient it being transferred to another facility: Attach a copy of the most current medication sheet(s). The sheet(s) should be reviewed for accuracy and signed by the discharging nurse.

Nurse's signature and Date: and **Patient/Guardian's signature and Date**: After reviewing the instructions with the patient/guardian, page 2 should be signed and dated by the nurse and the patient/guardian

PAGE 3: PHYSICAL & FUNCTIONAL STATUS

Patient's Name: Include the patient's full name

Activities of Daily Living on Discharge Day: On the day the patient is being discharged from your facility put the appropriate code for how the patient actually self performed the following activities:

ADL DEFINITIONS:

Transfer: How the patient moves between surfaces – i.e., to/from bed to chair, wheel chair or standing position (exclude from this definition movement to/from bath or toilet).

Walking: How the patient walks from place to place.

Dressing: How the patient puts on, fastens, and takes off all items of clothing.

Eating: How the patient eats and drinks, regardless of skill. Includes intake of nourishment by other means (i.e., tube feeding, total parenteral nutrition).

Toileting: How the patient uses the toilet room, commode, bedpan or urinal, transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, and adjusts clothes.

Bathing: How the patient takes a full-body bath/shower or sponge bath and transfers in/out of tub/shower. Exclude washing of back and hair.

Personal Hygiene: How the patient maintains personal hygiene including: combing hair, brushing teeth, applying makeup and washing/drying face, hands, and perineum. Exclude from this definition personal hygiene in baths and showers, which is covered under Bathing.

SELF PERFORMANCE CODES:

0 = Independent: No help or staff oversight provided during activity

1 = Supervision: Oversight, encouragement or cueing provided during activity

2 = Limited Assistance: Patient highly involved in activity, received physical help in guided maneuvering of limbs or other non-weight bearing assistance

3 = Extensive Assistance: Weight bearing support was provided but patient performed/assisted in part of the activity

4 = Total Dependence: Full staff performance of the activity, no participation from the patient in all aspects of the ADL definition

5 = Activity did not occur: The ADL activity was not performed by the staff or the patient

MOBILITY:

Upper Extremities: Check "Normal" if the patient has full range of motion on both sides, Check "Impaired" if the patient has limitations on one or both sides (Include fingers, wrists, and shoulders)

Lower Extremities: Check "Normal" if the patient has full range of motion on both sides, Check "Impaired" if the patient has limitations on one or both sides (Include hips, knees, and ankles)

Amputee: Check this box if the patient has any amputations and state location of amputation on the line provided

Prosthesis use: Check this box if the patient uses any prostheses and state type of prosthesis on the line provided

PAGE 3 (continued):

Equipment needed on discharge: Include all equipment the patient will need for ADL performance/support post discharge, i.e., standard walker, rolling walker, left lower leg prosthesis, weighted utensils, etc.

Stage and locate on diagram all decubitus ulcers: Include all pressure ulcers the patient currently has and stage as follows:

- **Stage 1:** A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.
- **Stage 2:** A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.
- **Stage 3:** A full thickness of skin is lost, exposing the subcutaneous tissues. Presents as a deep crater with or without undermining adjacent tissue.
- **Stage 4:** A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

Other wound present, describe: Include all other open areas and describe size and appearance

BOWEL AND BLADDER:

Bowel/Bladder Program – specify: If the patient is on a bowel or bladder program, include the name of that program, i.e., bowel retraining, bladder retraining, prompted voiding, habit training, scheduled toileting

Bladder Continence (choose one response): Put a checkmark for the best response:

- **Continent**: Complete control (including control achieved by care that involves prompted voiding, habit training, reminders, etc.)
- **Occasionally incontinent**: incontinent episodes occur two or more times per week but not daily
- **Frequently incontinent**: incontinent episodes tend to occur daily, but has some bladder control present
- **Incontinent**: Has inadequate bladder control, incontinence occurs multiple times daily

Bowel Continence (choose one response): Put a checkmark for the best response:

- **Continent**: Complete control (including control achieved by care that involves habit training, reminders, etc.)
- **Occasionally incontinent**: incontinent episodes occur once a week
- **Frequently incontinent**: incontinent episodes occur 2-3 times per week
- **Incontinent**: Has inadequate bowel control, incontinence occurs all (or almost all) of the time

Ostomy – (type/size): include type of ostomy (i.e., colostomy, ileostomy, nephrostomy) and size of appliance

Date of last BM: record the date the patient last had a bowel movement

Date foley changed: record the date the foley was last changed or date of insertion if not changed

Foley type and balloon size: record the type of catheter inserted and size of the balloon

Dialysis (*type*): If applicable, record the type of dialysis i.e. hemodialysis, peritoneal, etc.

PAGE 3 (continued):

VITAL SIGNS

Height: Record the patient's most recent height
Weight: Record the patient's most recent weight
Pulse range: Record the patient's pulse range over the past week
Resp. range: Record the patient's respiration range over the past week
Temp: Record the patient's temperature range over the past week
BP: Record the patient's blood pressure range over the past week
Pulse ox range: Record the patient's pulse ox range over the past week when not in oxygen
On Oxygen: Record the patient's pulse ox range over the past week while in oxygen
Pain score (1-10): If your facility uses a different pain scale to measure pain, please convert your answer to scale of 1 – 10

COGNITIVE STATUS

How well does the patient make decisions about organizing the day? (Choose one response):

Independent: The patient's decisions in organizing daily routine and making decisions were consistent, reasonable, and organized reflecting lifestyle, culture, values
Modified Independence: The patient organized daily routine and made safe decisions in familiar situations, but experienced some difficulty in decision making when faced with new tasks or situations
Moderately Impaired: The patient's decisions were poor; the patient required reminders, cues, and supervision in planning, organizing, and correcting daily routines
Severely Impaired: The patient never (or rarely) made decisions

Level of consciousness: Check only one response as they are listed below:

Alert, Drowsy but arousable with minor stimulation
Requires repeated stimulation to respond
Responds only with reflex motor or autonomic system
Effects or totally unresponsive

Mini Mental Health Examination: Check all that apply:

Patient is oriented to _____ person _____ year _____ place
Thought or speech organization, coherent
Maintains attention, not easily distracted
Short term memory okay – recalls 3 items (book, tree, house) after 5 minutes

PAGE 3 (continued):

COMMUNICATION

Primary Language: Record the language that the patient primarily speaks or understands in the space provided. Is the patient able to **Understand**, **Speak**, **Read**, and/or **Write** in the primary language? Check all that apply.

Secondary Language: If the patient speaks/understands a language other than the primary language, record that language in the space provided. Is the patient able to **Understand**, **Speak**, **Read**, and/or **Write** in the secondary language? Check all that apply.

Aphasia: Check if the patient has **Expressive** Aphasia or **Receptive** Aphasia
Sign Language: Check **yes** if the patient uses sign language, check **no** if the patient does not

IMPAIRMENTS – HEARING/VISUAL

Auditory (with hearing appliance if the patient uses one) Check the appropriate response(s):

Hears adequately: The patient hears all normal conversational speech, including when using the telephone, watching television, and engaged in group activities
Minimal difficulty: The patient hears speech at conversational levels but has difficulty hearing when not in quiet listening conditions or when not in one-on-one situations
Intermittently impaired: Although hearing deficient, the patient compensates when the speaker adjusts tonal quality and speaks distinctly; or the patient can hear only when the speaker's face is clearly visible
Highly impaired: The patient hears only some sounds and frequently fails to respond even when the speaker adjusts tonal quality, speaks distinctly, or is positioned face to face. There is no comprehension of conversational speech, even when the speaker makes maximum adjustments.

Has hearing device**: Check this if patient uses a hearing device and specify type used on the line provided

Vision (with glasses/visual appliance if used - i.e. eyeglasses, contact lenses or a magnifying glass for close vision)

Adequate: The patient sees fine detail, including regular print in newspapers/books
Impaired: The patient sees large print, but not regular print in newspapers/books
Moderately impaired: The patient has limited vision, is not able to see newspaper headlines
Severely impaired: The patient has no vision, sees only light, colors or shapes; or eyes do not appear to follow objects (especially people walking by)

Uses visual appliance**: Check this if patient uses a visual appliance and specify type of visual appliance used

COMMENTS: Describe any deviation in the patient's physical and/or functional status not addressed in the nursing discharge summary or in the above information

Nurse signature, Title and Date: and **Patient/Guardian's signature and Date**: The nurse completing this section must sign and date it.

PAGE 4:

Patient's Name: Include the patient's full name

Nursing Discharge Summary: This summary should be a brief description if the patient's stay at your facility along with the reason for the referral or transfer. This section should be used to communicate pertinent specific details regarding patient needs/preferences that would enhance the continued care of the patient. Information regarding **IV** is important and should be completed as appropriate.

Other Disciplines: All disciplines involved with the care of this patient should complete a summary of their interventions in the additional squares. All sections should contain the discipline, signature and title of the person completing the section, the date and their telephone number.

Rhode Island Department of Health
Continuity of Care Form

Patient Name: _____

Home Address: _____

_____

Being discharged to: _____

Address _____

_____ Phone: _____

Discharging Facility: _____

Contact Person: _____

Phone/Beeper: _____

Insurer: _____

Number: _____

Inpatient - Admission Date: _____ Discharge date: _____

Referral to: _____

Phone: _____

Patient demographic/registration sheet must be attached.
Copy of most recent lab results must be attached.
Copy of medications and IV sheets

For NH:
Other Facilities

SHADED AREAS TO BE COMPLETED BY PHYSICIAN

PRINCIPAL DIAGNOSIS OF THIS ADMISSION:

SURGERY THIS ADMISSION: **DATE:**

Does the patient have an Advance Directive?

☐ **No** ☐ **Yes** ☐ **FULL** ☐ **DNR** ☐ **CMO**

IMMUNIZATION(S) this admission:

☐ **FLU** ☐ **PNEUMOVAX**

TUBERCULIN STATUS, if known:

☐ **NEG** ☐ **POSITIVE** ☐ **UNKNOWN**

Allergies, list and describe reactions:

OTHER ACTIVE MEDICAL PROBLEMS:

INFECTIONS THIS ADMISSION AND SITE:

	Active	Resolved Date	Prior History
MRSA			
VRE			
C. Diff.			

Physician orders/treatments. Please specify number and frequency.

Diet: _____ Condition at Discharge: _____

Activity: _____

☐ Improved

☐ Unchanged

All medication(s) to be taken post discharge including those taken prior to admission:

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Patient's Name: _____

Instructions Until Next Doctor Visit	ALLOWED	SUPERVISED	NOT ALLOWED	Instructions Until Next Doctor Visit	ALLOWED	SUPERVISED	NOT ALLOWED
Drive car or ride a bike				Weight bearing			
Shower/tub bath				Stair climbing			
Housework				Participation in gym class			
Lifting (weight limit lbs.)				Contact/non-contact sports			
Contact with others				Return to work/school			
				Resume sexual activity		N/A	

Physician's Signature: _____ Date: _____

Address: _____

By signing, MD/DO verifies instructions above and on page one

Physician who will follow this patient after discharge (please print):

Name: _____

Phone: _____

Information given to patient on discharge

Written information given on medications: ☐

Pain instructions: ☐

Food/drug interaction information: ☐

Therapeutic diet instructions: ☐

Brochure CHF: ☐

Drug/drug interaction information: ☐

Smoking cessation brochure: ☐

Pain management information: ☐

Call physician if following occurs: _____

_____

_____

Follow-up appointments with phone numbers: _____

Wound Instructions: _____

_____

_____

Medications - Nurse writes in the actual times prescriptions are to be taken and circle the next time the drug is due.

MEDICATION ON DISCHARGE	DOSE	FREQUENCY	TIME LAST GIVEN	TIME NEXT DOSE	CONTINUE AFTER DISCHARGE YES	NO

New medications -- Prescription given ☐

Nurse's signature: _____

Date: _____

This information has been reviewed with me. I understand these instructions and accept responsibility to carry them out and bring this form to my next doctor/clinic appointment.

Patient's signature: _____

Discharge to parent or guardian- name/signature: _____

Interpreter's name: _____

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Physical & Functional Status - Nurse Form

Patient's Name: _____

Activities of Daily Living on Discharge Day

CODES:

____ Transfer
____ Walking
____ Dressing
____ Eating
____ Toileting
____ Bathing
____ Personal hygiene

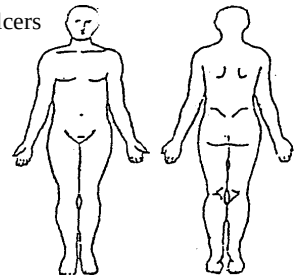
0 = Independent
1 = Supervision
2 = Limited assistance
3 = Extensive assistance
4 = Total dependence
5 = Activity did not occur

Mobility	Normal	Impaired
Upper extremities	____	____
Lower extremities	____	____

☐ Amputee _____
☐ Prothesis use _____
Equipment needed on discharge _____
_____

Stage and locate on diagram all decubitus ulcers

Stage 1 - area of persistent redness
Stage 2 - partial loss skin layers
Stage 3 - deep craters in skin
Stage 4 - breaks in skin, exposed muscle/bone



Other wounds present, describe:
_____

Bowel and Bladder

Bowel/Bladder Program - *specify* _____
Bladder Continence (choose one response)
____ Continent ____ Occasionally incontinent
____ Frequently incontinent ____ Incontinent
Bowel Continence (choose one response)
____ Continent ____ Frequent incontinent
____ Occasionally incontinent ____ Incontinent
Ostomy - (type/size) _____
Date of last BM: _____ Date foley changed _____
Foley type _____ and balloon size _____
Dialysis *(type):* _____

Vital Signs

Height: _____ Weight: _____
Pulse range : _____ Resp. range: _____
Temp: _____ BP : _____
On Oxygen: _____ %
pulse ox range: _____ Pain Score (0-10) ____

Cognitive Status

Cognitive skills for daily decision making

How well does the patient make decisions about organizing the day? (Choose one response)
____ Independent
____ Modified independence - some difficulty in new situations
____ Moderately impaired - decisions poor, cues and supervision needed
____ Severely impaired - never or rarely decides

Level of consciousness. (Choose one response)

____ Alert ____Drowsy but arousable with minor stimulation
____ Requires repeated stimulation to respond
____ Responds only with reflex motor or autonomic system
____ Effects or totally unresponsive

Mini Mental Health Examination

Patient is oriented to ____ person ____ year ____ place
____ Thought or speech organization, coherent
____ Maintains attention, not easily distracted
____ Short term memory okay - recalls 3 items (book, tree, house) after five minutes

Communication

Primary language: _____
Able to: ____ Understand ____ Speak ____ Read ____ Write

Secondary language: _____
Able to: ____ Understand ____ Speak ____ Read ____ Write

Aphasia: ____ Expressive ____ Receptive
Sign language use yes___ no___

Impairments - Hearing/Visual

Auditory (with hearing appliance if used)
____ Hears adequately
____ Minimal difficulty
____ Intermittently impaired
____ Highly impaired
____ Has hearing device**
**Specify type used _____

Vision (with glasses, if used)
____ Adequate
____ Impaired - sees large print but not regular print
____ Moderately impaired - limited vision cannot see headlines
____ Severely impaired - no vision or only sees light, color shapes
____ Uses visual appliance **
**Specify type used _____

COMMENTS (if necessary to describe any deviation not addressed in nursing discharge summary):

Nurse signature: _____ Title: _____ Date: _____

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Summary Notes - Specify Discipline
(for more information use additional sheets)

Patient Name:_____

Nursing Discharge Summary:

IV present: ☐ yes ☐ no Date Started_____ Time_____ IV Solution_____ Meds in IV_____ Rate_____

Date:_____ Unit phone:_____ Nurse signature:_____

Discipline:_____

Date:_____ Phone:_____ Signature/title:_____

Discipline:_____

Date:_____ Phone: _____ Signature/title:_____

ORIGINAL - agency COPY 1 - physician/agency COPY 2 - chart

Rhode Island Department of Health
Continuity of Care
Consultation Form

Patient going to:_____

Address:_____

_____

Patient Name:_____

Date of Birth:_____ Date:_____

Attending Physician:_____

Phone:_____

Facility/Address:_____

Phone:_____ Floor/Unit/Room:_____

Facility Contact:_____

Next of Kin:_____

Relationship:_____

Phone:_____

Reason for transfer:

Attach the following:

- ☐ Face Sheet/Demographic Sheet
- ☐ Diagnosis Sheets/Problem List
- ☐ Advanced Directive
- ☐ Recent X-ray (if applicable)
- ☐ Medication Sheets
- ☐ Recent Lab Results (if applicable)

Explain Reason for Visit:

- ☐ Follow up
- ☐ Acute Accident, *specify*
- ☐ Annual Exam
- ☐ Consult, *ordered by:*_____
- ☐ Other, *specify*

Brief description of problem:

Nurse's Name:_____ Phone:_____

Physician's findings, recommendations and/or orders for the medical necessity of continuance of professional care (nursing, therapy, dietary, other). Specify treatment frequency, duration and extent. Include activity limitations.

Attach the following:

- ☐ Physicians Notes & Diagnoses
- ☐ Test Results

Follow up visit required: ☐ No ☐ Yes, Appointment Date & Time_____

Physician's Name (please print)_____ Phone:_____

Physician's Signature:_____

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